

Post Traumatic Stress Disorder (PTSD) In Litigation

PTSD is a mental disorder that is frequently part of tort litigation. Yet few disorders are subject to as much misunderstanding and misuse. It is far from a new disorder, however. In fact, the phenomenon has been recognized by the general public for some time, just under different names. At various times, PTSD has been called “compensation neurosis,” “shell shock,” and “battle fatigue. ” The criteria which make up the diagnosis is made have also evolved over time. Currently, DSM-IV, that compendium of diagnostic criteria, states that to qualify as a diagnosis of PTSD, the individual must have been exposed to a traumatic event in which **both** of the following have occurred: 1) the person “experienced, witnessed or was actually confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others” **AND** the person’s response to that event “involved intense fear, helplessness or horror.”

Assuming the above occurred, the trauma must be **persistently re-experienced** in one or more of these ways:

- 1) recurrent and intrusive memories of the event
- 2) recurrent and distressing dreams of the event
- 3) acting or feeling as though the event was re-occurring (“flashbacks”)
- 4) intense emotional upset when exposed to cues that symbolize aspects of the original trauma
- 5) bodily reactivity when exposed to cues that symbolize aspects of the original trauma

Moreover, the subject must **persistently avoid** stimuli connected with the original trauma, and feel have a decrease in responsiveness, as indicated by 3 or more of these:

- 1) attempts to avoid thoughts, feelings or conversations associated with the trauma
- 2) attempts to avoid activities, places or people that bring back memories of the trauma
- 3) inability to remember important aspects of the trauma
- 4) reduced involvement or interest in significant activities
- 5) feeling detached from other people
- 6) reduced range of emotional responsiveness
- 7) feeling that one’s future is foreshortened

But wait! There’s more to the diagnosis! Additionally, the individual must display persistent indications of “**increased arousal**” with 2 or more of these symptoms:

- 1) problems with sleep (falling or staying asleep)
- 2) irritability
- 3) problems with concentration
- 4) exaggerated alertness to threats in the environment
- 5) exaggerated “jumpiness”

A shorthand way of remembering all this is to recall that PTSD requires a major trauma and 2 A’s and an R: avoidance and arousal plus re-experiencing of the original trauma.

All of the above need to have been **present for more than one month** and must cause significant impairment or distress in the individual’s functioning. If the symptoms have a shorter duration, the correct diagnosis is “acute stress disorder.”

The first important thing to understand is that the **original trauma must be a genuinely dangerous event**. No matter how anxious the individual is currently, no matter how many symptoms s/he is displaying, if that first criterion is not met, there cannot be a diagnosis of PTSD! If, for instance, someone is phobic about heights and finds himself on the rooftop of a tall building and subsequently displays the symptoms of PTSD, that diagnosis cannot be made because the initial event does not qualify as truly dangerous. **That initial event must be objectively life-threatening or at least very dangerous.**

If you’re defending against a claim of PTSD, it’s important to know that the diagnostic criteria are very subjective and rely to a great extent on patient self-report and clinical judgment. (For suggestions on how to combat the latter, see my article “Challenging the Mental Health Witness” and “Is Diagnosis Useless in Litigation,” both on this website.) There is no psychological test that can prove that any observed or reported symptoms are due to a specific event. Nor are there any that can prove that the individual is being truthful---or that s/he is lying, for that matter! If Mary is displaying symptoms, how do we know that they’re due to this particular trauma and not to a long-standing (but totally unrelated) emotional problem? And how do we know that her symptoms are genuine and not exaggerated, if not outright feigned? Her therapist is not a good source of information: for the reason why, read “Why Your Client’s Therapist Is The Worst Possible Expert for Your Case” on this website.

The consensus in the field is that an approach called “multi-trait, Multi-method” is the most comprehensive way to determine if there is true PTSD. What this means is integrating data from a variety of sources rather than only from the client’s self-report. Testing (such as the MMPI) and possibly structured interviews, combined with reports from the claimant’s family and associates will provide a fuller, potentially more objective conclusion than client interview alone.

A good way to think of the genuine PTSD client is to say that s/he is “stuck in time:” they continually re-experience their trauma, replete with all the emotional side-effects of that experience. The PTSD sufferer is consumed with a need for safety and self-protection. This need can become more important than the need for human connection and major deficits in interpersonal trust are common. PTSD can be hard to diagnose, because some people will understandably shy away from bringing up very painful memories. Some researchers have found that true PTSD can exist for over 50 years! And PTSD is commonly found along with other emotional problems (common ones are depression, anxiety and substance abuse), thus further complicating the diagnosis.

PTSD is a genuine emotional disturbance, one that causes a great deal of distress and can be incapacitating. However, it is also true that it is a diagnosis that has become well known in the lay community and can be abused in litigation. For further clarification of this conundrum, just give me a call at 650-368-8318.